Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

12460

5 - SUMMARIES

[redacted]

HISTORY AND PHYSICAL EXAMINATION

CHIEF COMPLAINT: The patient is a 64-year-old woman who comes in with a cerebrovascular accident.

PRESENT ILLNESS: History is a little confusing. The patient says that she felt fine through the day of 11/10. She had gone to bed and was lying down watching TV, when she got too close to the edge of the bed and fell to the floor. After landing on the floor on her back, she said that she was unable to move an get up. Eventually her granddaughters, who were in another room, came and found her. They called the EMT's. By the time they arrived, she was unable to use her right arm and right leg. She had a sagging right side of her face suggesting strongly that she had had a cerebrovascular accident.

It is a little difficult to reconstruct the whole thing. The fact that she said that she had fallen out of bed while still able to move all extremities would suggest that one should look at the possibility of an intracranial bleed or subdural hematoma, although the presentation was much more that of a cerebrovascular accident. The patient seems slightly confused, although oriented to time, place, and person. She just wasn't quite herself, and the speculation is that what really happened is that she fell trying to get into bed and doesn't remember it. One would have to assume at that point that she had a CVA and fell to the floor on that basis.

The patient was sent from the Emergency Room, after arrival and initial quick work-up, over to [redacted] for a CAT scan. Consideration was twofold. The most cogent of them, in the short run, was worry about intracranial bleed and/or evidence of intracranial increased pressure from the history suggestive of trauma. It was thought that this probably was a red herring, but it was felt that it was necessary to rule it out. The CAT scan, to my reading, and without contrast, is within normal limits. It shows no midline shift, and no accumulation of blood. The other consideration was that this seemed to be a very young woman for a cerebrovascular accident. She had no known predisposing factors, had not had recent surgery, was on no anticoagulation, the onset had been sudden, and she seemed like a good candidate for consideration of TPA therapy. However, between 9:30 in the evening when she had the episode, till we managed to get her back to the hospital from the CAT scan (close to four hours), she was considered not a candidate for that kind of intervention. I talked to Dr. [redacted] at [redacted] in that

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SIGNATURE OF PHYSICIAN DATE

[redacted] M.D.

PATIENT'S IDENTIFICATION (CHART NUMBER, NAME-LAST, FIRST, HOME TOWN, DOB)

[redacted]

[redacted]

HISTORY AND PHYSICAL

[redacted]

regard, and he said that she had gone beyond the time limit for doing the TPA therapy. They are not doing it much in [redacted] basically she would have to be in a hospital that had a CAT scanning capability on premises. I explained this to the relatives.

PAST HISTORY

MEDICAL HISTORY: The patient has no known preceding hypertension, although she has been checked at various times for it. Apparently at some point, somebody must have thought she had labile hypertension, but all the recordings I can find look pretty much normal. She doesn't have any known heart disease.

The patient has known diverticulitis, and known diverticulosis of the left and sigmoid colon. Internal and external hemorrhoids.

The patient has had four pregnancies and four children.

SURGICAL HISTORY: She has had a total abdominal hysterectomy and bilateral salpingo-oophorectomy in 1982. Known uterine fibroids which led to the abdominal hysterectomy.

The patient had a right breast nodule that was removed in 1983 and turned out to be fibroadenomatous disease.

MEDICATIONS: Multivitamins once a day, and recently has been taking melatonin once a day also.

FAMILY HISTORY: She does have history of a sister who has had some cardiac disease and high blood pressure. Mother is 85 and in reasonably good health, but is going in for some bowel work-up in the near future.

SOCIAL HISTORY: The patient is generally an active, healthy individual. Retired about a month ago from [redacted] where she worked in admissions. She had not been sick in any way recently.

The patient is married. Her husband has high blood pressure. She had benign habits.

HABITS: Nonsmoker, nondrinker.

HEALTH MAINTENANCE: Patient had a positive PPD and was treated with INH for about a year back in 1974.

Her most recent Pap and mammogram were negative in 12/95, and she is due for repeat of those and has an appointment in 12/96.

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SIGNATURE OF PHYSICIAN DATE

[redacted] M.D.

PATIENT'S IDENTIFICATION (CHART NUMBER, NAME-LAST, FIRST, HOME TOWN, DOB)

[redacted]

[redacted]

PHYSICAL EXAMINATION

GENERAL: The patient is alert and oriented. In no distress. Unable to move her right arm and right leg. Somewhat dysarthric with a drooping right side of the face which has improved markedly. The little bit of confusion she seemed to be suffering from when she arrived is receding, although she is still insisting that she is going to get up and walk to the bathroom despite the fact that she can't use the right side of her body, and is insistent that she is going home tomorrow. That may be more stubbornness than anything else.

VITAL SIGNS: Blood pressure 174/70, pulse 86, temperature 97:8, oxygen saturation 94% on 2 liters.

HEENT: Fundi look benign. Discs are sharp. Pupils are equally reactive to light. Extraocular movements are full. Tympanic membranes are normal. Nose and throat are unremarkable.

NECK: Supple. Carotids are normal. Thyroid feels normal. She has what feels like a torticollis on the right side, which she says has been there forever, and she has a clear, hard, sort of contracted, sternocleidomastoid muscle on that side. I am trying to find evidence that this has been noted previously. She insists that it has been there since she was a small child. Pulses are full and equal. No evidence of meningeal irritation. Kernig and Brudzinski are negative. Extraocular movements are full. Pupils are equally reactive to light. Gag reflex is normal. Tongue is midline.

HEART: Normal rhythm without murmurs.

LUNGS: Chest is clear to percussion and auscultation.

ABDOMEN: Abdominal examination shows no liver, spleen, or kidney palpable. Bowel sounds are normal. She has a midline, lower abdominal scar from the abdominal hysterectomy. No pain in any quadrant.

EXTREMITIES: Pulses are full and equal in femoral, popliteal, dorsalis pedis, and posterior tibial.

SKIN: Normal.

NEUROLOGIC: Drooping of the right side of the face. There seems to be more lower facial than upper facial involvement, although she is not able to completely close her eye. The cranial nerves are otherwise intact. The patient's right arm shows paresis with normal-to-slightly increased reflexes. Sensory is within normal limits.

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SIGNATURE OF PHYSICIAN *DATE*

[redacted] M.D.

PATIENT'S IDENTIFICATION (CHART NUMBER, NAME-LAST, FIRST, HOME TOWN, DOB)

[redacted] [redacted]

She has a dense hemiparesis right arm and leg. Unable to lift right leg, unable to wiggle toes or fingers. The deep tendon reflexes in the lower extremity are essentially normal. Toe is up-going on that side. Left side has normal range of motion, normal reflexes, and toe down-going. The patient's muscle tone is normal on the left side. No atrophy or loss of tone on the right side at this time.

The patient is oriented to time, place, and person. No neurocutaneous findings.

LAB DATA: EKG is within normal limits. Axis are normal. No injury current. White count is 10,900, hematocrit 41, hemoglobin 14, platelet count 266. Glucose 125, creatinine 1.0, cholesterol very slightly elevated at 219, as is triglyceride at 219. Electrolytes are normal. Sodium 145, potassium 3.6, PT 11.8 with INR 0.97 and PTT is 25.4.

IMPRESSION:

1. Cerebrovascular accident.
2. Torticollis right side, said to have been there long term. Will have to check old records to see whether indeed that can be confirmed.
3. Status post total abdominal hysterectomy.
4. Breast biopsy for benign lesion in the 80's.
5. In need of Pap smear and mammogram in 12/96.

PLAN: Admitted. Observation. Aspirin. Fluids. Will consider a repeat CAT scan down the road, in a couple of days, for mapping and documentation, particularly if things are not improving. Physical therapy.

ADDENDUM: The area that I was calling a torticollis persists in being palpable. It seems softer now (about 3.5 hours after admission). Initially, patient said that she had had this for most of her lifetime. Her daughters were unaware of that. She now tells me that she hasn't had it there before. I think this is consistent with the mild confusion that she seems to be displaying, and her persistence in wanting to get up and go to the bathroom even though that is not possible for her at the moment. In any case, I did a Doppler ~~tracing~~ of the area, and the carotid pulse on that side is most prominent over the area of swelling. It is not pulsatile. It extends up to the angle of the jaw. I am beginning to wonder whether it might represent a carotid aneurysm. However, it is on the "wrong" side to be an etiology for left sided cerebrovascular accident affecting the right side of the body. I discussed the matter with Dr. [redacted], who is covering for Dr. [redacted]. He is going to take a look at the findings this morning. It is not something that he feels any urgent intervention is necessary for, and finds it would be hard to understand how that could be the cause of the present troubles. In any case, we will look at it this morning, and will discuss the matter further after his evaluation. Obviously, if it is considered to be a possibility, more extensive studies will be necessary.

[redacted]

D&T: 11/11/96

SIGNATURE O[redacted] DATE

[redacted] M.D.

PATIENT'S IDENTIFICATION (CHART NUMBER, NAME-LAST, FIRST, HOME TOWN, DOB)

[redacted]

[redacted]

NARRATIVE SUMMARY

DATE OF ADMISSION	DATE OF DISCHARGE	NUMBER OF DAYS HOSPITALIZED
11/11/96	Transferred 11/24/96	013

PROBLEM: 1. Right cerebrovascular accident.
2. Torticollis right side.

BRIEF HISTORY: The patient is a 64-year-old Native woman, admitted on 11/11/96 with a sudden change in CNS function. At the time of admission, she was noted to have a drooping of the right side of her face, and a dense right hemiparesis. She was oriented to time, place, and person. She had no preexisting chronic illnesses or risk factors for a stroke.

The only medication she was taking prior to admission was a diet medication called Shape Fast which contains Ma Huang (an ephedrine-like substance), ephedrine, and caffeine.

At the time of admission, the patient was referred to [redacted] for CT scan, which showed mild-to-moderate cerebral atrophy. No hemorrhage or acute CVA was detected.

PLEASE SEE ADMISSION HISTORY AND PHYSICAL

IMMEDIATE MANAGEMENT: The patient was admitted to the Medical Ward and treated conservatively and supportively for a left sided CVA. She was given oxygen and placed on telemetry, IV fluids, and an Internal Medicine consultation was obtained. The patient was started on 1 aspirin q. d., and low dose heparin for DVT prophylaxis. She was initially started on low doses of captopril for her blood pressure, which was subsequently discontinued. Consultations were obtained from Physical Therapy, Respiratory Therapy, and Occupational Therapy. On November 12, a duplex carotid ultrasound was performed which showed occlusion of the left internal carotid artery, probably acute. She also underwent an echocardiogram which showed no source for embolic phenomenon from the heart. There was no indication for anticoagulation based on that study.

LAB DATA: On admission, with an IV: Glucose 125, creatinine 1.0, electrolytes were normal. Liver function tests were normal. Cholesterol 219, hemoglobin 14.2, hematocrit 41.1. Urinalysis was within normal limits. PTT and PT were normal.

Follow-up CT scan done on 11/14, showed a hemorrhagic infarction involving primarily the left basal ganglia with edema seen extending into the left parietal and temporal lobes. There was a relatively mild focal mass effect without any noticeable shift in the midline structures or ventricular obstruction. A CT of her neck showed no soft-tissue mass, lymphadenopathy, or cystic lesions. The jugular vein was noticeably more distended on the right side, and there was a partial contraction of the right sternocleidomastoid muscle. There was a small calcified plaque at the right carotid artery bifurcation. The aspirin and low dose heparin were discontinued.

An x-ray of the hip and femur were negative on 11/13. These were obtained after the patient fell down while on the floor.

HOSPITAL COURSE: The patient's physical condition slowly improved over the

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SIGNATURE OF PHYSICIAN DATE

[redacted] M.D.

PATIENT'S IDENTIFICATION (CHART NUMBER, NAME-LAST, FIRST, HOME TOWN, DOB)

[redacted]

[redacted]

NARRATIVE SUMMARY

DATE OF ADMISSION	DATE OF DISCHARGE	NUMBER OF DAYS HOSPITALIZED
Page 2.		

course of her hospitalization, with improvement of her speech and swallowing. She had no evidence of seizure activity during her hospitalization. Her blood pressures, off medication, were 144-152/76-84. She received Physical Therapy twice a day, and was able to transfer, with assistance, and was starting to learn how to dress herself. Her diet progressed to dental soft which she was tolerating well. A patient care conference held on 11/19 demonstrated a very supportive family structure, and a great interest in a rehabilitation program. I spoke with Dr. [redacted] at [redacted] who stated that he would be making referral to the [redacted] for a rehabilitation program.

On 11/20, I learned that the patient would be accepted into the program, and that she should travel on Sunday, 11/24.

LONG TERM MANAGEMENT: The patient will be transferred to the [redacted] for a rehabilitation program on Sunday, 11/24, with her husband, [redacted] as her escort. She should be able to transfer to and from the airports with a taxi, needing wheelchair assistance at both terminals.

MEDICATIONS AT DISCHARGE:
1. Colace 100 mg p.o. b.i.d.
2. Multi vitamins 1 p.o. q. d.
3. Tylenol p.r.n.
4. Milk-of-Magnesia p.r.n.
5. Valium 5 mg p.o. q. hs. p.r.n. sleep.

DISCHARGE DIAGNOSES:
1. Hemorrhagic infarction of the brain involving primarily the left basal ganglia.
2. Resultant right hemiplegia.

[redacted]
D&T: 11/21/96

SIGNATURE OF PHYSICIAN [redacted] M.D. DATE

PATIENT'S IDENTIFICATION (CHART NUMBER, NAME-LAST, FIRST, HOME TOWN, DOB)

[redacted]

[redacted]

CONSULTATION

Patient: [redacted]
DOB:
Chart [redacted]
Date of Service: 11/11/96
Date of Report: 11/11/96

REFERRING PHYSICIAN: [redacted] *M.D.*

REASON FOR CONSULT: *This is a 64-year-old woman female who was admitted to* [redacted] *in the early morning hours of 11/11/96 with a stroke involving her right side with involvement of right hand and arm, right leg, some dysarthria, and no apparent dysphasia. She did not appear very confused at the time of my examination, originally, but there is some question as to whether there may be more confusion present as she is observed.*

BRIEF HISTORY: *The past history is not remarkable. She has no known risk factors that would have made one expect her to be a candidate for stroke. She is, at admission, afebrile. Her blood pressure was 174/70 and then dropped down to 146/80.*

PHYSICAL EXAM: *The right lid seems to lag a bit at the time of this examination. She has slight asymmetry in the smile, and the extremities show complete flaccidity of the right arm and right leg. She seems to be alert and oriented at the time of this examination. The patient is seen specifically with regard to the mass on the right side of her neck which appears to represent a nodule some 2 cm in diameter at the angle of the mandible under the sternocleidomastoid muscle. The question that arose is whether this might represent an aneurysm. If it be aneurysm, it is thrombosed completely and since it is nontender, I doubt seriously that it represents this change. I suspect, from this examination, that it represents a lymph node, possibly involved in metastatic tumor. This would also raise the question of whether the central nervous system lesion might be metastatic tumor with degeneration and hemorrhage rather than a usual stroke.*

It is my feeling that there is no reason to become aggressive about this mass in the neck at this point. She needs to be managed for the acute stroke in progress, have an evaluation by CT scan to determine what is going on there, and at the same time, this would give us some idea about the mass in the neck. She can be followed from that point depending on how she is resolving. The nature of the mass in the neck does need to be determined, but does not take priority over stroke care.

[redacted] *M.D.*

[redacted]
D&T: 11/11/96

[redacted]